C-IRO Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/05/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-5 mini 360 fusion and 2 day inpatient stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery with fellowship training in Spine Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the requested L4-5 mini 360 fusion and 2 day inpatient stay is not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Prior utilization reviews 12/02/14 and 01/07/15

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on xx/xx/xx when she slipped and fell injuring her low back. No clinical documentation was submitted for review other than prior utilization reviews from 12/02/14 and 01/07/15. Per these utilization reviews MRI reportedly showed disc herniations at L4-5. The patient had continued pain despite physical therapy and injections. Physical examination reportedly showed positive straight leg raise signs bilaterally with paraspinal lumbar tenderness to palpation. The patient was reported to be cleared for surgery on 10/27/14. The requested three the requested L4-5 360 degree lumbar fusion with two day inpatient stay was denied on 12/02/14 as there was no evidence of segmental instability or arch defect. The patient did not have prior failed surgery. The request was again denied on 01/07/15 as there was no evidence for instability or radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient was followed for persistent complaints of low back pain that failed conservative treatment. This reviewer did not receive any clinical documentation from the requesting physician or any imaging studies detailing pathology at L4-5 to the extent lumbar fusion would be required under guidelines. Due to paucity of clinical information available to support the surgical request it is the opinion of this reviewer that the requested L4-5 mini 360 fusion and 2 day inpatient stay is not medically necessary. Therefore the prior denials are upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)